		FOR OHF USE					

LL1

2003
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2003)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0003020

Facility Name: MENARD CONVALESCENT CENTER

Address: 120 W. ANTLE (Number) PETERSBURG (City) 62675 (Zip Code)

County: MENARD

Telephone Number: (217) 632-2249 **Fax #** (217) 632-2314

IDPA ID Number: 37-0856151001

Date of Initial License for Current Owners: 12/1/66

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: JERRY W. JENNINGS **Telephone Number:** (217) 787-8530

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 12/01/02 to 11/30/03 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) JERRY W. JENNINGS
(Title) CONTROLLER

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number MENARD CONVALESCENT CENTER # 0003020 Report Period Beginning: 12/01/02 Ending: 11/30/03

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	87,911	8,706	4,642	101,259		101,259		101,259			1
2	Food Purchase		61,608		61,608		61,608	(1,766)	59,842			2
3	Housekeeping	36,716	7,689		44,405		44,405		44,405			3
4	Laundry	24,844	10,132		34,976		34,976		34,976			4
5	Heat and Other Utilities			51,479	51,479		51,479		51,479			5
6	Maintenance	28,225	22,551	28,421	79,197		79,197	783	79,980			6
7	Other (specify):* Utility Workers	17,250			17,250		17,250		17,250			7
8	**TOTAL General Services**	194,946	110,686	84,542	390,174		390,174	(983)	389,191			8
	B. Health Care and Programs											
9	Medical Director	12,033		6,700	18,733		18,733		18,733			9
10	Nursing and Medical Records	683,228	104,681	180,098	968,007	(74,554)	893,453	3,259	896,712			10
10a	Therapy	20,890	2,399	153,570	176,859	(153,570)	23,289		23,289			10a
11	Activities	35,771	2,183		37,954		37,954		37,954			11
12	Social Services	3,837		4,794	8,631		8,631		8,631			12
13	Nurse Aide Training		51	350	401		401		401			13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	755,759	109,314	345,512	1,210,585	(228,124)	982,461	3,259	985,720			16
	C. General Administration											
17	Administrative	50,242		8,473	58,715	1,870	60,585	24,612	85,197			17
18	Directors Fees											18
19	Professional Services			80,784	80,784		80,784	(72,502)	8,282			19
20	Dues, Fees, Subscriptions & Promotions			19,933	19,933		19,933	(11,861)	8,072			20
21	Clerical & General Office Expenses	24,335	12,254	5,641	42,230		42,230	17,779	60,009			21
22	Employee Benefits & Payroll Taxes			160,883	160,883		160,883	10,195	171,078			22
23	Inservice Training & Education			1,833	1,833		1,833	575	2,408			23
24	Travel and Seminar			5,502	5,502	(4,252)	1,250	380	1,630			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			100,033	100,033		100,033	198	100,231			26
27	Other (specify):*			42,626	42,626		42,626	(42,626)				27
28	**TOTAL General Administration**	74,577	12,254	425,708	512,539	(2,382)	510,157	(73,250)	436,907			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,025,282	232,254	855,762	2,113,298	(230,506)	1,882,792	(70,974)	1,811,818			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number MENARD CONVALESCENT CENTER # 0003020 Report Period Beginning: 12/01/02 Ending: 11/30/03

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	59	Skilled (SNF)	59	21,535	1
2		Skilled Pediatric (SNF/PED)			2
3	27	Intermediate (ICF)	27	9,855	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	86	TOTALS	86	31,390	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			2,323	2,323	8
9	SNF/PED					9
10	ICF	10,812	3,218		14,030	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	10,812	3,218	2,323	16,353	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 52.10%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 1966

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 30 and days of care provided 2,323

Medicare Intermediary ADMINASTAR FEDERAL OF KENTUCKY

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 11/30/03 Fiscal Year: 11/30/03

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number MENARD CONVALESCENT CENTER #0003020 **Report Period Beginning:** 12/01/02 **Ending:** 11/30/03

V. COST CENTER EXPENSES (continued)

		Cost Per General Ledger				Reclass-	Reclassified	Adjust-	Adjusted	FOR OHF USE ONLY		
	Capital Expense	Salary/Wage	Supplies	Other	Total	ification	Total	ments	Total			
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			18,747	18,747		18,747	4,253	23,000			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			8,099	8,099		8,099	(67)	8,032			32
33	Real Estate Taxes			13,462	13,462		13,462		13,462			33
34	Rent-Facility & Grounds							3,084	3,084			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			40,308	40,308		40,308	7,270	47,578			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					230,506	230,506		230,506			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			47,085	47,085		47,085		47,085			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			47,085	47,085	230,506	277,591		277,591			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,025,282	232,254	943,155	2,200,691		2,200,691	(63,704)	2,136,987			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number MENARD CONVALESCENT CENTER # 0003020 Report Period Beginning: 12/01/02 Ending: 11/30/03

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(330)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	3,134	30		9
10	Interest and Other Investment Income	(67)	32		10
11	Discounts, Allowances, Rebates & Refunds	(465)	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(2,208)	27		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(12,285)	27		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(77)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(28,133)	27		24
25	Fund Raising, Advertising and Promotional	(11,499)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(362)	20		28
29	Other-Attach Schedule VENDING	(1,436)	2		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (53,728)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(9,976)	Various	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (9,976)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (63,704)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39	Therapy	X		153,570	10a	39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology	X		2,225	10	42
43	Prescription Drugs	X		53,424	10	43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule Oxygen	X		13,634	10	45
46	Other-Attach Schedule MC Supplies	X		7,653	10	46
47	**TOTAL (C): (sum of lines 38-46)**			$ 230,506		47

STATE OF ILLINOIS

MENARD CONVALESCENT CENTER

ID# 0003020

Report Period Beginning: 12/01/02

Ending: 11/30/03

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number MENARD CONVALESCENT CENTER **#** 0003020 **Report Period Beginning:** 12/01/02 **Ending:** 11/30/03

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(330)	0	0	0	0	0	0	0	0	0	0	(330)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(330)	0	0	0	0	0	0	0	0	0	0	(330)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	171	0	0	0	0	0	0	0	0	0	171	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(77)	(73,195)	0	0	0	0	0	0	0	0	0	(73,272)	19
20	Fees, Subscriptions & Promotions	(11,861)	0	0	0	0	0	0	0	0	0	0	(11,861)	20
21	Clerical & General Office Expenses	(465)	0	0	0	0	0	0	0	0	0	0	(465)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	(171)	0	0	0	0	0	0	0	0	0	(171)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(42,626)	0	0	0	0	0	0	0	0	0	0	(42,626)	27
28	**TOTAL General Administration**	(55,029)	(73,195)	0	0	0	0	0	0	0	0	0	(128,224)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(55,359)	(73,195)	0	0	0	0	0	0	0	0	0	(128,554)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number MENARD CONVALESCENT CENTER # 0003020 **Report Period Beginning:** 12/01/02 **Ending:** 11/30/03

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	3,134	0	0	0	0	0	0	0	0	0	0	3,134	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(67)	0	0	0	0	0	0	0	0	0	0	(67)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	3,067	0	0	0	0	0	0	0	0	0	0	3,067	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(52,292)	(73,195)	0	0	0	0	0	0	0	0	0	(125,487)	45

Facility Name & ID Number MENARD CONVALESCENT CENTER # 0003020 Report Period Beginning: 12/01/02 Ending: 11/30/03

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SAM KLEIN	43%	D'ADRIAN CONVALESCENT CENTER, INC.	GODFREY	Nrsg Home Mngrs	SPRINGFIELD	MANAGEMENT
H. RAYMOND KLEIN	7%	HILLTOP NURSING HOME, INC.	CHARLESTON			
ROBERT SCHAFER	25%	JACKSONVILLE CONVALESCENT CENTER, INC	JACKSONVILLE			
BARRY FREE	25%	MEADOW MANOR, INC.	TAYLORVILLE			
		SUNRISE MANOR OF VIRDEN, INC.	VIRDEN			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	19	MANAGEMENT FEE	$ 80,422	NURSING HOME MANAGERS, INC.	50.00%	$	$ (80,422)	1
2	V	Var.	SEE ATTACHED SCHEDULES		NURSING HOME MANAGERS, INC.	50.00%	63,219	63,219	2
3	V	19	ACCOUNTING		NURSING HOME MANAGERS, INC. DIRECT ALLOCATION	50.00%	7,227	7,227	3
4	V	24	TRAVEL	171	TO TRANSFER 31% OF HOME OFFICE TRAVEL	50.00%		(171)	4
5	V	17	ADMINISTRATIVE		TO ADMINISTRATIVE PER DESK REVIEW	50.00%	171	171	5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 80,593			$ 70,617	$ * (9,976)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number MENARD CONVALESCENT CENTER # 0003020 Report Period Beginning: 12/01/02 Ending: 11/30/03

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week: Hours	Percent	Compensation Included in Costs for this Reporting Period**: Description	Amount	Schedule V. Line & Column Reference	
1	H. RAYMOND KLEIN	OWNER	MANAGEMENT	7.00					$ 1,430	17 - 7	1
2	ROBERT SCHAFER	MED. DIRECTOR	MED. DIRECTOR	25.00		6	12.00		12,033	9 - 1	2
3											3
4											4
5											5
6			H. RAYMOND KLEIN WAS PAID BY NURSING HOME MANAGERS, INC.,								6
7			A RELATED ORGANIZATION. TOTAL COMPENSATION OF $10,010 WAS								7
8			ALLOCATED AMONG THE SIX RELATED NURSING HOMES, BASED								8
9			UPON 10 HOURS PER WEEK.								9
10											10
11											11
12											12
13								TOTAL	$ 13,463		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number MENARD CONVALESCENT CENTER # 0003020 Report Period Beginning: 12/01/02 Ending: 11/30/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: NURSING HOME MANAGERS, INC.
Street Address: 2653 WEST LAWRENCE - SUITE B
City / State / Zip Code: SPRINGFIELD, IL 62704
Phone Number: (217) 787-8530
Fax Number: (217) 787-9840

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2		SEE ATTACHED SCHEDULES								2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number MENARD CONVALESCENT CENTER # 0003020 Report Period Beginning: 12/01/02 Ending: 11/30/03

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	BANK OF SPRINGFIELD		X	WORKING CAPITAL		12/10/02	75,000	150,000	12/10/03	0.0425	5,093	6
7	SAM KLEIN ESTATE	X		WORKING CAPITAL		05/30/03	25,000	295,000	DEMAND	0.0425	3,006	7
8												8
9	TOTAL Facility Related						$ 100,000	$ 445,000			$ 8,099	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 100,000	$ 445,000			$ 8,099	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** _____ **Line #** _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number MENARD CONVALESCENT CENTER # 0003020 Report Period Beginning: 12/01/02 Ending: 11/30/03

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2002 report.	$ 12,616	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$ 13,606	2
3. Under or (over) accrual (line 2 minus line 1).	$ 990	3
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)	$ 12,472	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$ 13,462	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1998	13,488	8
	1999	13,870	9
	2000	13,705	10
	2001	13,764	11
	2002	13,606	12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2002	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

LINE 4: ACCRUAL 11/12 X $13,606 = $12,472

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME MENARD CONVALESCENT CENTER COUNTY MENARD

FACILITY IDPH LICENSE NUMBER 0003020

CONTACT PERSON REGARDING THIS REPORT JERRY W. JENNINGS

TELEPHONE (217) 787-8530 FAX #: (217) 787-9840

A. **Summary of Real Estate Tax Cos**

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 200

	(A) Tax Index Numbe	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	11-14-219-009	MENARD CONV. CENTER, INC.	$ 521.84	$ 521.84
2.	11-14-229-001	MENARD CONV. CENTER, INC.	$ 304.40	$ 304.40
3.	11-14-228-002	MENARD CONV. CENTER, INC.	$ 488.86	$ 488.86
4.	11-14-228-001	MENARD CONV. CENTER, INC.	$ 11,379.42	$ 11,379.42
5.	11-14-227-001	MENARD CONV. CENTER, INC.	$ 816.16	$ 816.16
6.	11-14-219-006	MENARD CONV. CENTER, INC.	$ 95.92	$ 95.92
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 13,606.60	$ 13,606.60

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. **Tax Bills**

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill whic is normally paid during 2003.

Facility Name & ID Number MENARD CONVALESCENT CENTER # 0003020 Report Period Beginning: 12/01/02 Ending: 11/30/03

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 19,211 B. General Construction Type: Exterior MASONRY Frame STEEL Number of Stories 1

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	NURSING HOME	93,436	1963 - 1964	$ 9,919	1
2					2
3	TOTALS	93,436		$ 9,919	3

Facility Name & ID Number MENARD CONVALESCENT CENTER # 0003020 Report Period Beginning: 12/01/02 Ending: 11/30/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	54		1966	1966	$ 172,985	$ 1,397	30	$	$ (1,397)	$ 172,985	4
5	32		1974	1974	148,705	1,754	30		(1,754)	148,705	5
6											6
7											7
8											8
	Improvement Type**										
9	LANDSCAPING			1966	5,308					5,308	9
10	FIRE DOORS			1979	1,433					1,433	10
11	FIRE DOORS			1981	8,340					8,340	11
12	BATHROOM			1984	7,335		30	245	245	4,776	12
13	AIR CONDITIONER			1984	1,100		8			1,100	13
14	ELECTRICAL & PLUMBING			1985	11,117	128	15		(128)	11,117	14
15	PLUMBING			1986	4,921	207	15		(207)	4,921	15
16	SMOKE DETECTORS			1986	10,445	439	25	417	(22)	7,314	16
17	AIR CONDITIONER			1986	2,235	94	10		(94)	2,235	17
18	PLUMBING			1986	1,145	48	20	58	10	999	18
19	ROOF			1987	6,362	233	20	318	85	5,247	19
20	WATER HEATER & WINDOWS			1988	6,530	207	15		(207)	6,530	20
21	NURSE CALL			1988	1,674	53	10		(53)	1,674	21
22	ROOF			1989	30,672	974	20	1,534	560	22,242	22
23	WATER HEATER & PARKING LOT			1989	11,502	365	15	767	402	11,121	23
24	FURNACE & FLOORING			1990	19,165	608	15	1,278	670	17,252	24
25	AIR CONDITIONER			1991	2,633	84	15	175	91	2,198	25
26	PLUMBING FAUCETS			1992	8,909	283	15	594	311	6,831	26
27	DOOR ALARM			1992	1,572	50	20	78	28	1,024	27
28	WATER HEATER & GARAGE DOOR			1993	4,348	138	15	290	152	3,045	28
29	WATER HEATER & PLUMBING			1994	5,074	130	15	338	208	3,212	29
30	LANDSCAPING			1994	3,900	260	15	260		2,405	30
31	AIR CONDITIONER & ROOF			1995	7,049	181	15	470	289	3,995	31
32	REMODEL BATHROOMS - TILE, CEILING, FIXTURES			1996	19,751	506	15	1,316	810	9,876	32
33	AIR CONDITIONER			1997	1,710	44	15	114	70	741	33
34	FIRE DAMPERS			1998	4,076	105	15	272	167	1,495	34
35	FURNACE			1998	2,200	56	15	147	91	807	35
36	GREASE TRAP			1999	2,824	72	15	188	116	847	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete

See Page 12A, Line 70 for total

Facility Name & ID Number MENARD CONVALESCENT CENTER # 0003020 Report Period Beginning: 12/01/02 Ending: 11/30/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	CEILING REPAIR	2002	$ 4,935	$ 126	15	$ 329	$ 203	$ 631	37
38	AIR CONDITIONING	2002	2,102	54	15	140	86	163	38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 522,057	$ 8,596		$ 9,328	$ 732	$ 470,569	70

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number MENARD CONVALESCENT CENTER # 0003020 Report Period Beginning: 12/01/02 Ending: 11/30/03

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 126,723	$ 8,237	$ 11,871	$ 3,634	VAR	$ 80,384	71
72	Current Year Purchases	12,167	1,914	682	(1,232)	VAR	682	72
73	Fully Depreciated Assets	140,921					140,921	73
74		(73,230)					(73,230)	74
75	TOTALS	$ 206,581	$ 10,151	$ 12,553	$ 2,402		$ 148,757	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 738,557	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 18,747	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 21,881	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 3,134	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 619,326	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number MENARD CONVALESCENT CENTER # 0003020 Report Period Beginning: 12/01/02 Ending: 11/30/03

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N / A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2004	$
13.	/2005	$
14.	/2006	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ Description:
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number MENARD CONVALESCENT CENTER # 0003020 Report Period Beginning: 12/01/02 Ending: 11/30/03

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [X]
- HOURS PER AIDE ____

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1 Facility Drop-outs	2 Facility Completed	3 Contract	4 Total
1	Community College Tuition	$	$ 300	$	$ 300
2	Books and Supplies		51		51
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests		50		50
9	TOTALS	$	$ 401	$	$ 401
10	SUM OF line 9, col. 1 and 2 (e)	$ 401			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	1
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	1

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number MENARD CONVALESCENT CENTER # 0003020 Report Period Beginning: 12/01/02 Ending: 11/30/03

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39	hrs	$	1,870	$ 69,198	$	1,870	$ 69,198	1
2	Licensed Speech and Language Development Therapist	39	hrs		267	13,181		267	13,181	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39	hrs		1,863	71,191		1,863	71,191	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts				53,424		53,424	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): Oxy,MC Sup,Xray,Lab	39					23,512		23,512	13
14	TOTAL			$	4,000	$ 153,570	$ 76,936	4,000	$ 230,506	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number MENARD CONVALESCENT CENTER # 0003020 Report Period Beginning: 12/01/02 Ending: 11/30/03

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 11/30/03 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 10,903	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	274,372		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	23,228		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 308,503	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	9,919		13
14	Buildings, at Historical Cost	522,057		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	275,357		16
17	Accumulated Depreciation (book methods)	(674,875)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 132,458	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 440,961	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 594,923	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	50,707		30
31	Accrued Taxes Payable (excluding real estate taxes)	4,619		31
32	Accrued Real Estate Taxes(Sch.IX-B)	12,472		32
33	Accrued Interest Payable	349		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 663,070	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 663,070	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (222,109)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 440,961	$	48

***(See instructions.)**

Facility Name & ID Number MENARD CONVALESCENT CENTER # 0003020 Report Period Beginning: 12/01/02 Ending: 11/30/03

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 301,167	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 301,167	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(523,276)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (523,276)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (222,109)	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number MENARD CONVALESCENT CENTER # 0003020 Report Period Beginning: 12/01/02 Ending: 11/30/03

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 1,723,160	1
2	Discounts and Allowances for all Levels	(114,729)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 1,608,431	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	63,034	6
7	Oxygen	3,652	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 66,686	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	67	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 67	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	**Vending $1,436 Expense Reimbursement $330**	1,766	28
28a	**W/A $90 Admit Fee $375**	465	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 2,231	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 1,677,415	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	390,174	31
32	Health Care	1,210,585	32
33	General Administration	512,539	33
	B. Capital Expense		
34	Ownership	40,308	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	47,085	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,200,691	40
41	**Income before Income Taxes (line 30 minus line 40)****	(523,276)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (523,276)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number MENARD CONVALESCENT CENTER # 0003020 Report Period Beginning: 12/01/02 Ending: 11/30/03

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,920	1,960	$ 45,528	$ 23.23	1
2	Assistant Director of Nursing					2
3	Registered Nurses	4,312	4,445	77,307	17.39	3
4	Licensed Practical Nurses	12,747	13,278	206,688	15.57	4
5	Nurse Aides & Orderlies	38,596	39,865	353,705	8.87	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,935	2,052	20,890	10.18	8
9	Activity Director	1,779	1,833	15,290	8.34	9
10	Activity Assistants	2,826	2,840	20,481	7.21	10
11	Social Service Workers	485	507	3,837	7.57	11
12	Dietician					12
13	Food Service Supervisor	1,895	2,134	23,773	11.14	13
14	Head Cook					14
15	Cook Helpers/Assistants	9,039	9,416	64,138	6.81	15
16	Dishwashers					16
17	Maintenance Workers	3,537	3,700	28,225	7.63	17
18	Housekeepers	5,393	5,468	36,716	6.71	18
19	Laundry	3,232	3,742	24,844	6.64	19
20	Administrator	2,000	2,080	50,242	24.15	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	2,002	2,184	24,335	11.14	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director	300	300	12,033	40.11	27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) Utility Workers	3,015	3,090	17,250	5.58	33
34	TOTAL (lines 1 - 33)	95,013	98,894	$ 1,025,282 *	$ 10.37	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	145	$ 4,642	1 - 3	35
36	Medical Director	100	6,700	9 - 3	36
37	Medical Records Consultant	16	515	10 - 3	37
38	Nurse Consultant	906	38,659	10 - 3	38
39	Pharmacist Consultant	96	1,874	10 - 3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	82	4,794	12 - 3	45
46	Other(specify)				46
47	Medicare Consultant	192	16,851	10 - 3	47
48	Administrative Consultant	260	8,473	17 - 3	48
49	TOTAL (lines 35 - 48)	1,797	$ 82,508		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	119	$ 4,830	10 - 3	50
51	Licensed Practical Nurses	1,438	46,787	10 - 3	51
52	Nurse Aides	3,148	70,582	10 - 3	52
53	TOTAL (lines 50 - 52)	4,705	$ 122,199		53

Facility Name & ID Number MENARD CONVALESCENT CENTER # 0003020 Report Period Beginning: 12/01/02 Ending: 11/30/03

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
JULIA SMITH	ADMINISTRATOR	0	$ 50,242
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 50,242

B. Administrative - Other

Description	Amount
ADMINISTRATIVE CONSULTANT	$ 8,473
TOTAL (agree to Schedule V, line 17, col. 3)	$ 8,473
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
NURSING HOME MANAGERS	MANAGEMENT FEE	$ 80,422
C S C	CORP. REPRESENTATION	285
FELDMAN, WASSER, ETAL	LEGAL	77
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 80,784

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 37,738
Unemployment Compensation Insurance	7,673
FICA Taxes	77,094
Employee Health Insurance	
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE CAFETERIA PLAN	34,271
EMPLOYEE LIFE INSURANCE	2,599
HOLIDAY PARTIES	344
EMPLOYEE GIFT CERTIFICATES	980
VACCINES	184
NHM ALLOCATION	10,195
TOTAL (agree to Schedule V, line 22, col.8)	$ 171,078

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
HOLIDAY PARTIES	22	$ 344
GIFT CERTIFICATES	22	980
VACCINES	22	184
TOTAL		$ 1,508

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 750
Advertising: Employee Recruitment	6,499
Health Care Worker Background Check	518
(Indicate # of checks performed 43)	
YELLOW PAGES	362
PUBLIC RELATIONS	11,499
FOOD SERVICE LICENSE	100
ADMINISTRATOR LICENSE	100
FRANCHISE FEES	105
NHM ALLOCATION	0
Less: Public Relations Expense	(11,499)
Non-allowable advertising	( )
Yellow page advertising	(362)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 8,072

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
MISC MILEAGE REIMBURSEMENT	1,250
TRANSFER HOME OFFICE	(171)
NHM ALLOCATION	551
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,630

**See instructions.

Facility Name & ID Number MENARD CONVALESCENT CENTER # 0003020 Report Period Beginning: 12/01/02 Ending: 11/30/03

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008
1	PAINTING	6/90	$ 1,471	3 YRS	$	$	$	$	$	$	$	$	$
2	PAINTING	7/91	1,450	3 YRS									
3	PAINTING	7/94	2,726	3 YRS									
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 5,647		$	$	$	$	$	$	$	$	$

Facility Name & ID Number MENARD CONVALESCENT CENTER **#** 0003020 **Report Period Beginning:** 12/01/02 **Ending:** 11/30/03

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **NO**

(2) Are there any dues to nursing home associations included on the cost report? **NO**
If YES, give association name and amount.

(3) Did the nursing home make political contributions or payments to a politica action organization? **NO** If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **8 YEARS**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **374** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **47,085**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **YES** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **0**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.

SCHEDULE V - PAGES 3 & 4

PAGE 3 - LINE 27 - COLUMN 3
OTHER GENERAL ADMINISTRATION

SALES TAX	$	2,208
BAD DEBT		28,133
FINES & PENALTIES		12,285
	$	42,626

COLUMN 5 - RECLASSIFICATIONS

			LINE #
RECLASS FROM:			
X-RAY	$	(212)	10
LABS		(2,013)	10
MEDICARE DRUGS		(53,424)	10
MEDICARE SUPPLIES		(7,653)	10
OXYGEN		(13,634)	10
PHYSICAL THERAPY		(71,191)	10A
SPEECH THERAPY		(13,181)	10A
OCCUPATIONAL THERAPY		(69,198)	10A
RECLASS TO:			
ANCILLARY	$	230,506	39

RECLASS TO:			
NURSE CONSULTANT TRAVEL	$	2,382	10
ADMINISTRATIVE CONS. TRAVEL		1,870	17
RECLASS FROM:			
TRAVEL	$	(4,252)	24

SCHEDULE III - PAGE 2

QUESTION K - NUMBER OF CERTIFIED BEDS

12/01/02 - 03/31/03	19
04/01/03 - 11/30/03	30

SCHEDULE XI - PAGE 13 - SECTION E

RECONCILIATION OF DEPRECIATION

LINE 83 - STRAIGHT LINE DEPRECIATION	$	21,881
NURSING HOME MANAGERS ALLOCATION		1,119
SCHEDULE V - LINE 30 - COLUMN 8	$	23,000

SCHEDULE XVII - PAGE 19

RECONCILIATION OF INCOME	
LINE 41 - NET INCOME	$ (523,276)
* ACCRUED MANAGEMENT FEE 11/02	(8,967)
* ACCRUED MANAGEMENT FEE 11/03	5,481
INTEREST INCOME PASSED DIRECTLY TO STOCKHOLDERS	(67)
TAXABLE INCOME	$ (526,829)

* RELATED PARTY ACCOUNTS PAYABLE NOT ALLOWED FOR TAX PURPOSES INCLUDED HERE FOR CONSISTENCY WITH PRIOR COST REPORTS AND TO CONFORM TO ACCRUAL ACCOUNTING METHODS.

SCHEDULE XX - PAGE 23 - QUESTION 12

SALARY COSTS ALLOCATED TO DEPARTMENT WORKED BASED UPON TIME CARDS.

SCHEDULE VII - PAGE 6, LINE 2

CENTRAL OFFICE COST ALLOCATION
MENARD
2003

	DEC 02	JAN 03	FEB	MARCH	APRIL	MAY	JUNE	JULY	AUG	SEPT	OCT	NOV	2002 TOTAL	LINE #
SALARIES-ADMIN	$1,913	$1,857	$1,725	$1,677	$1,725	$1,734	$1,780	$1,728	$2,152	$2,242	$2,169	$2,307	$23,011	17
SALARIES-CLERIC	1,384	1,354	1,258	1,223	1,258	1,265	1,298	1,260	1,440	1,500	1,451	1,544	16,235	21
SALARIES-ACTIV	0	0	0	0	0	0	0	0	0	0	0	0	0	
SALARIES-NURSE	142	339	315	306	315	316	325	315	215	224	217	231	3,259	10
ACCOUNTING	51	124	116	112	116	116	119	116	(24)	(25)	(25)	(26)	770	19
WORK COMP INS	19	23	21	21	21	21	22	21	2	2	2	2	178	22
SUPPLIES	115	99	92	90	92	93	95	92	50	52	51	54	975	21
TELEPHONE	76	99	92	90	92	93	95	92	74	77	75	79	1,034	21
EMPL BENEFITS	718	548	510	495	510	512	526	510	644	671	649	691	6,984	22
PAYROLL TAXES	239	302	280	273	280	282	289	281	196	204	197	210	3,033	22
TRAVEL	30	47	44	43	44	44	45	44	51	53	51	54	551	24
IN SERVICE	74	45	42	40	42	42	43	42	50	52	50	54	575	23
MEDICAL CONSULT	0	0	0	0	0	0	0	0	0	0	0	0	0	
MACHINE RENTAL	14	36	34	33	34	34	35	34	15	15	15	16	314	6
OWNERS COMP	123	119	111	108	111	111	114	111	127	132	127	136	1,430	17
INS-PROP,LIAB,WC	7	15	14	14	14	14	14	14	22	23	23	24	198	26
DEPRECIATION	61	91	85	82	85	85	87	85	111	116	112	119	1,119	30
RENT	253	251	234	227	234	235	241	234	285	297	288	306	3,084	34
MAINTENANCE	56	45	42	41	42	42	43	42	28	29	28	30	469	6
FEES & PUBLICAT	0	0	0	0	0	0	0	0	0	0	0	0	0	20
ADVERTISING		0	0	0	0	0	0	0	0	0	0	0	0	20
		0	0	0	0	0	0	0	0	0	0	0	0	
TOTAL	$5,278	$5,395	$5,014	$4,874	$5,013	$5,039	$5,174	$5,021	$5,439	$5,664	$5,480	$5,830	$63,219	
FIXED ASSETS													63,219	
EQUIP - PRIOR	8,314	9,026	8,388	5,400	5,554	5,583	5,732	5,563	6,179	6,435	6,226	6,623	6,585	
EQUIP - CURR	768	0	0	2,320	2,386	2,398	2,462	2,389	2,986	3,110	3,009	3,201	2,086	
EQUIP - FULLY DEP	2,776	2,759	2,564	2,493	2,564	2,577	2,646	2,567	2,852	2,970	2,873	3,057	2,725	
BLDG - PRIOR	978	972	903	878	903	908	932	904	1,005	1,046	1,012	1,077	960	
BLDG - CURR	0	0	0	0	0	0	0	0	0	0	0	0	0	
BLDG - FULLY DEP	0	0	0	0	0	0	0	0	0	0	0	0	0	

MONTHLY CENTRAL OFFICE COST ALLOCATIONS

NURSING HOME MANAGERS
COST ALLOCATION
DECEMBER 2002

	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
ALLOC PERCENT	4.42%	17.00%	23.85%	17.58%	14.54%	22.61%	100.00%
SALARIES-ADMIN	$582	$2,237	$3,138	$2,313	$1,913	$2,975	$13,158
SALARIES-CLERIC	421	1,618	2,269	1,673	1,384	2,151	9,517
SALARIES-ACTIV	0	0	0	0	0	0	0
SALARIES-NURSE	43	166	233	172	142	221	978
ACCOUNTING	16	60	84	62	51	80	352
WORK COMP INS	6	22	31	23	19	29	128
SUPPLIES	35	135	189	140	115	179	794
TELEPHONE	23	89	125	92	76	119	525
EMPL BENEFITS	218	840	1,178	868	718	1,116	4,938
PAYROLL TAXES	73	279	392	289	239	372	1,644
TRAVEL	9	35	50	37	30	47	208
IN SERVICE	23	87	122	90	74	115	510
MEDICAL CONSULT	0	0	0	0	0	0	0
MACHINE RENTAL	4	16	23	17	14	21	95
OWNERS COMP	37	144	202	149	123	191	847
INS-PROP,LIAB,WC	2	8	11	8	7	10	45
DEPRECIATION	19	71	100	74	61	95	419
RENT	77	296	415	306	253	393	1,739
MAINTENANCE	17	65	92	68	56	87	385
FEES & PUBLIC	0	0	0	0	0	0	0
ADVERTISING	1	3	5	3	3	4	19
	0	0	0	0	0	0	0
TOTAL	$1,606	$6,171	$8,656	$6,382	$5,278	$8,206	$36,300
FIXED ASSETS							
EQUIP - PRIOR	2,530	9,721	13,635	10,053	8,314	12,926	57,179
EQUIP - CURR	234	898	1,259	929	768	1,194	5,281
EQUIP - FULLY DEP	845	3,246	4,553	3,357	2,776	4,316	19,092
BLDG - PRIOR	298	1,143	1,604	1,182	978	1,520	6,725
BLDG - CURR	0	0	0	0	0	0	0
BLDG - FULLY DEP	0	0	0	0	0	0	0

NURSING HOME MANAGERS
COST ALLOCATION
JANUARY 2003

	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
ALLOC PERCENT	0.00%	18.14%	26.03%	18.33%	14.45%	23.05%	100.00%
SALARIES-ADMIN	$0	$2,331	$3,344	$2,356	$1,857	$2,961	$12,848
SALARIES-CLERIC	0	1,700	2,439	1,718	1,354	2,160	$9,370
SALARIES-ACTIV	0	0	0	0	0	0	$0
SALARIES-NURSE	0	425	610	429	339	540	$2,343
ACCOUNTING	0	156	224	158	124	198	$861
WORK COMP INS	0	29	41	29	23	36	$158
SUPPLIES	0	124	179	126	99	158	$686
TELEPHONE	0	124	179	126	99	158	$686
EMPL BENEFITS	0	688	988	696	548	875	$3,795
PAYROLL TAXES	0	379	543	383	302	481	$2,087
TRAVEL	0	59	85	60	47	76	$328
IN SERVICE	0	56	81	57	45	71	$310
MEDICAL CONSULT	0	0	0	0	0	0	$0
MACHINE RENTAL	0	46	65	46	36	58	$251
OWNERS COMP	0	150	215	151	119	190	$825
INS-PROP,LIAB,WC	0	19	27	19	15	24	$104
DEPRECIATION	0	114	164	116	91	145	$631
RENT	0	315	453	319	251	401	$1,739
MAINTENANCE	0	57	82	57	45	72	$313
FEES & PUBLIC	0	0	0	0	0	0	$0
ADVERTISING	0	0	0	0	0	0	$0
	0	0	0	0	0	0	$0
TOTAL	$0	$6,772	$9,717	$6,845	$5,395	$8,605	$37,335
FIXED ASSETS							
EQUIP - PRIOR	0	11,330	16,257	11,451	9,026	14,396	62,460
EQUIP - CURR	0	0	0	0	0	0	0
EQUIP - FULLY DEP	0	3,463	4,969	3,500	2,759	4,400	19,092
BLDG - PRIOR	0	1,220	1,750	1,233	972	1,550	6,725
BLDG - CURR	0	0	0	0	0	0	0
BLDG - FULLY DEP	0	0	0	0	0	0	0

NURSING HOME MANAGERS
COST ALLOCATION
FEBRUARY 2003

	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
ALLOC PERCENT	0.00%	18.59%	26.13%	18.79%	13.43%	23.05%	100.00%
SALARIES-ADMIN	$0	$2,389	$3,358	$2,414	$1,725	$2,962	$12,848
SALARIES-CLERIC	0	1,742	2,449	1,761	1,258	2,160	$9,370
SALARIES-ACTIV	0	0	0	0	0	0	$0
SALARIES-NURSE	0	436	612	440	315	540	$2,343
ACCOUNTING	0	160	225	162	116	198	$861
WORK COMP INS	0	29	41	30	21	36	$158
SUPPLIES	0	128	179	129	92	158	$686
TELEPHONE	0	128	179	129	92	158	$686
EMPL BENEFITS	0	706	992	713	510	875	$3,795
PAYROLL TAXES	0	388	545	392	280	481	$2,087
TRAVEL	0	61	86	62	44	76	$328
IN SERVICE	0	58	81	58	42	71	$310
MEDICAL CONSULT	0	0	0	0	0	0	$0
MACHINE RENTAL	0	47	66	47	34	58	$251
OWNERS COMP	0	153	216	155	111	190	$825
INS-PROP,LIAB,WC	0	19	27	20	14	24	$104
DEPRECIATION	0	117	165	118	85	145	$631
RENT	0	323	454	327	234	401	$1,739
MAINTENANCE	0	58	82	59	42	72	$313
FEES & PUBLIC	0	0	0	0	0	0	$0
ADVERTISING	0	0	0	0	0	0	$0
	0	0	0	0	0	0	$0
TOTAL	$0	$6,942	$9,757	$7,015	$5,014	$8,607	$37,335
FIXED ASSETS							
EQUIP - PRIOR	0	11,614	16,322	11,736	8,388	14,400	62,460
EQUIP - CURR	0	0	0	0	0	0	0
EQUIP - FULLY DEP	0	3,550	4,989	3,587	2,564	4,402	19,092
BLDG - PRIOR	0	1,250	1,757	1,264	903	1,550	6,725
BLDG - CURR	0	0	0	0	0	0	0
BLDG - FULLY DEP	0	0	0	0	0	0	0

NURSING HOME MANAGERS
COST ALLOCATION
MARCH 2003

	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
ALLOC PERCENT	0.00%	18.42%	26.49%	19.41%	13.06%	22.62%	100.00%
SALARIES-ADMIN	$0	$2,367	$3,404	$2,494	$1,677	$2,906	$12,848
SALARIES-CLERIC	0	1,726	2,482	1,819	1,223	2,119	$9,370
SALARIES-ACTIV	0	0	0	0	0	0	$0
SALARIES-NURSE	0	432	621	455	306	530	$2,343
ACCOUNTING	0	159	228	167	112	195	$861
WORK COMP INS	0	29	42	31	21	36	$158
SUPPLIES	0	126	182	133	90	155	$686
TELEPHONE	0	126	182	133	90	155	$686
EMPL BENEFITS	0	699	1,005	737	495	858	$3,795
PAYROLL TAXES	0	385	553	405	273	472	$2,087
TRAVEL	0	60	87	64	43	74	$328
IN SERVICE	0	57	82	60	40	70	$310
MEDICAL CONSULT	0	0	0	0	0	0	$0
MACHINE RENTAL	0	46	66	49	33	57	$251
OWNERS COMP	0	152	219	160	108	187	$825
INS-PROP,LIAB,WC	0	19	28	20	14	24	$104
DEPRECIATION	0	116	167	122	82	143	$631
RENT	0	320	461	338	227	393	$1,739
MAINTENANCE	0	58	83	61	41	71	$313
FEES & PUBLIC	0	0	0	0	0	0	$0
ADVERTISING	0	0	0	0	0	0	$0
	0	0	0	0	0	0	$0
TOTAL	$0	$6,877	$9,891	$7,248	$4,874	$8,444	$37,335
FIXED ASSETS							
EQUIP - PRIOR	0	7,620	10,959	8,030	5,400	9,356	41,365
EQUIP - CURR	0	3,273	4,707	3,449	2,320	4,019	17,768
EQUIP - FULLY DEP	0	3,517	5,058	3,706	2,493	4,318	19,092
BLDG - PRIOR	0	1,239	1,782	1,306	878	1,521	6,725
BLDG - CURR	0	0	0	0	0	0	0
BLDG - FULLY DEP	0	0	0	0	0	0	0

NURSING HOME MANAGERS
COST ALLOCATION
APRIL 2003

	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
ALLOC PERCENT	0.00%	18.58%	25.71%	19.78%	13.43%	22.50%	100.00%
SALARIES-ADMIN	$0	$2,387	$3,303	$2,542	$1,725	$2,891	$12,848
SALARIES-CLERIC	0	1,741	2,409	1,854	1,258	2,108	$9,370
SALARIES-ACTIV	0	0	0	0	0	0	$0
SALARIES-NURSE	0	435	602	463	315	527	$2,343
ACCOUNTING	0	160	221	170	116	194	$861
WORK COMP INS	0	29	41	31	21	36	$158
SUPPLIES	0	127	176	136	92	154	$686
TELEPHONE	0	127	176	136	92	154	$686
EMPL BENEFITS	0	705	975	751	510	854	$3,795
PAYROLL TAXES	0	388	537	413	280	470	$2,087
TRAVEL	0	61	84	65	44	74	$328
IN SERVICE	0	58	80	61	42	70	$310
MEDICAL CONSULT	0	0	0	0	0	0	$0
MACHINE RENTAL	0	47	65	50	34	56	$251
OWNERS COMP	0	153	212	163	111	186	$825
INS-PROP,LIAB,WC	0	19	27	21	14	23	$104
DEPRECIATION	0	117	162	125	85	142	$631
RENT	0	323	447	344	234	391	$1,739
MAINTENANCE	0	58	81	62	42	71	$313
FEES & PUBLIC	0	0	0	0	0	0	$0
ADVERTISING	0	0	0	0	0	0	$0
	0	0	0	0	0	0	$0
TOTAL	$0	$6,937	$9,597	$7,387	$5,013	$8,400	$37,335
FIXED ASSETS							
EQUIP - PRIOR	0	7,686	10,633	8,184	5,554	9,307	41,365
EQUIP - CURR	0	3,302	4,567	3,515	2,386	3,998	17,768
EQUIP - FULLY DEP	0	3,548	4,908	3,777	2,564	4,296	19,092
BLDG - PRIOR	0	1,250	1,729	1,331	903	1,513	6,725
BLDG - CURR	0	0	0	0	0	0	0
BLDG - FULLY DEP	0	0	0	0	0	0	0

NURSING HOME MANAGERS
COST ALLOCATION
MAY 2003

	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
ALLOC PERCENT	0.00%	17.92%	26.31%	19.02%	13.50%	23.25%	100.00%
SALARIES-ADMIN	$0	$2,303	$3,381	$2,444	$1,734	$2,987	$12,848
SALARIES-CLERIC	0	1,679	2,465	1,782	1,265	2,179	$9,370
SALARIES-ACTIV	0	0	0	0	0	0	$0
SALARIES-NURSE	0	420	616	446	316	545	$2,343
ACCOUNTING	0	154	226	164	116	200	$861
WORK COMP INS	0	28	42	30	21	37	$158
SUPPLIES	0	123	180	130	93	159	$686
TELEPHONE	0	123	181	131	93	160	$686
EMPL BENEFITS	0	680	998	722	512	882	$3,795
PAYROLL TAXES	0	374	549	397	282	485	$2,087
TRAVEL	0	59	86	62	44	76	$328
IN SERVICE	0	56	82	59	42	72	$310
MEDICAL CONSULT	0	0	0	0	0	0	$0
MACHINE RENTAL	0	45	66	48	34	58	$251
OWNERS COMP	0	148	217	157	111	192	$825
INS-PROP,LIAB,WC	0	19	27	20	14	24	$104
DEPRECIATION	0	113	166	120	85	147	$631
RENT	0	312	458	331	235	404	$1,739
MAINTENANCE	0	56	82	60	42	73	$313
FEES & PUBLIC	0	0	0	0	0	0	$0
ADVERTISING	0	0	0	0	0	0	$0
	0	0	0	0	0	0	$0
TOTAL	$0	$6,692	$9,823	$7,101	$5,039	$8,680	$37,335
FIXED ASSETS							
EQUIP - PRIOR	0	7,414	10,883	7,867	5,583	9,617	41,365
EQUIP - CURR	0	3,185	4,675	3,379	2,398	4,131	17,768
EQUIP - FULLY DEP	0	3,422	5,023	3,631	2,577	4,439	19,092
BLDG - PRIOR	0	1,205	1,769	1,279	908	1,564	6,725
BLDG - CURR	0	0	0	0	0	0	0
BLDG - FULLY DEP	0	0	0	0	0	0	0

NURSING HOME MANAGERS
COST ALLOCATION
JUNE 2003

	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
ALLOC PERCENT	0.00%	18.25%	25.82%	18.98%	13.86%	23.10%	100.00%
SALARIES-ADMIN	$0	$2,344	$3,318	$2,439	$1,780	$2,967	$12,848
SALARIES-CLERIC	0	1,710	2,419	1,778	1,298	2,164	9,370
SALARIES-ACTIV	0	0	0	0	0	0	0
SALARIES-NURSE	0	427	605	445	325	541	2,343
ACCOUNTING	0	157	222	163	119	199	861
WORK COMP INS	0	29	41	30	22	37	158
SUPPLIES	0	125	177	130	95	158	686
TELEPHONE	0	125	177	130	95	158	686
EMPL BENEFITS	0	692	980	720	526	876	3,795
PAYROLL TAXES	0	381	539	396	289	482	2,087
TRAVEL	0	60	85	62	45	76	328
IN SERVICE	0	57	80	59	43	72	310
MEDICAL CONSULT	0	0	0	0	0	0	0
MACHINE RENTAL	0	46	65	48	35	58	251
OWNERS COMP	0	151	213	157	114	191	825
INS-PROP,LIAB,WC	0	19	27	20	14	24	104
DEPRECIATION	0	115	163	120	87	146	631
RENT	0	317	449	330	241	402	1,739
MAINTENANCE	0	57	81	59	43	72	313
FEES & PUBLIC	0	0	0	0	0	0	0
ADVERTISING	0	0	0	0	0	0	0
	0	0	0	0	0	0	0
TOTAL	$0	$6,812	$9,640	$7,086	$5,174	$8,623	$37,335
FIXED ASSETS							
EQUIP - PRIOR	0	7,548	10,681	7,851	5,732	9,553	41,365
EQUIP - CURR	0	3,242	4,588	3,372	2,462	4,104	17,768
EQUIP - FULLY DEP	0	3,484	4,930	3,624	2,646	4,409	19,092
BLDG - PRIOR	0	1,227	1,736	1,276	932	1,553	6,725
BLDG - CURR	0	0	0	0	0	0	0
BLDG - FULLY DEP	0	0	0	0	0	0	0

NURSING HOME MANAGERS
COST ALLOCATION
JULY 2003

	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
ALLOC PERCENT	0.00%	18.33%	26.94%	19.06%	13.45%	22.22%	100.00%
SALARIES-ADMIN	$0	$2,355	$3,461	$2,449	$1,728	$2,855	$12,848
SALARIES-CLERIC	0	1,717	2,524	1,786	1,260	2,082	9,370
SALARIES-ACTIV	0	0	0	0	0	0	0
SALARIES-NURSE	0	429	631	447	315	521	2,343
ACCOUNTING	0	158	232	164	116	191	861
WORK COMP INS	0	29	43	30	21	35	158
SUPPLIES	0	126	185	131	92	152	686
TELEPHONE	0	126	185	131	92	152	686
EMPL BENEFITS	0	695	1,022	723	510	843	3,795
PAYROLL TAXES	0	383	562	398	281	464	2,087
TRAVEL	0	60	88	62	44	73	328
IN SERVICE	0	57	84	59	42	69	310
MEDICAL CONSULT	0	0	0	0	0	0	0
MACHINE RENTAL	0	46	68	48	34	56	251
OWNERS COMP	0	151	222	157	111	183	825
INS-PROP,LIAB,WC	0	19	28	20	14	23	104
DEPRECIATION	0	116	170	120	85	140	631
RENT	0	319	468	332	234	386	1,739
MAINTENANCE	0	57	84	60	42	70	313
FEES & PUBLIC	0	0	0	0	0	0	0
ADVERTISING	0	0	0	0	0	0	0
	0	0	0	0	0	0	0
TOTAL	$0	$6,843	$10,057	$7,117	$5,021	$8,297	$37,335
FIXED ASSETS							
EQUIP - PRIOR	0	7,582	11,142	7,886	5,563	9,193	41,365
EQUIP - CURR	0	3,257	4,786	3,387	2,389	3,949	17,768
EQUIP - FULLY DEP	0	3,499	5,143	3,640	2,567	4,243	19,092
BLDG - PRIOR	0	1,233	1,812	1,282	904	1,495	6,725
BLDG - CURR	0	0	0	0	0	0	0
BLDG - FULLY DEP	0	0	0	0	0	0	0

NURSING HOME MANAGERS
COST ALLOCATION
AUGUST 2003

	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
ALLOC PERCENT	0.00%	18.33%	26.84%	18.24%	14.94%	21.65%	100.00%
SALARIES-ADMIN	$0	$2,641	$3,868	$2,629	$2,152	$3,120	$14,410
SALARIES-CLERIC	0	1,767	2,588	1,759	1,440	2,087	9,641
SALARIES-ACTIV	0	0	0	0	0	0	0
SALARIES-NURSE	0	264	387	263	215	312	1,442
ACCOUNTING	0	(30)	(44)	(30)	(24)	(35)	(163)
WORK COMP INS	0	3	4	3	2	3	14
SUPPLIES	0	62	90	61	50	73	336
TELEPHONE	0	91	133	90	74	107	496
EMPL BENEFITS	0	790	1,158	787	644	934	4,313
PAYROLL TAXES	0	240	352	239	196	284	1,311
TRAVEL	0	62	91	62	51	74	340
IN SERVICE	0	61	90	61	50	72	334
MEDICAL CONSULT	0	0	0	0	0	0	0
MACHINE RENTAL	0	18	27	18	15	21	99
OWNERS COMP	0	155	227	155	127	183	847
INS-PROP,LIAB,WC	0	28	40	27	22	33	150
DEPRECIATION	0	136	200	136	111	161	744
RENT	0	350	513	349	285	414	1,911
MAINTENANCE	0	34	50	34	28	40	186
FEES & PUBLIC	0	0	0	0	0	0	0
ADVERTISING	0	0	0	0	0	0	0
	0	0	0	0	0	0	0
TOTAL	$0	$6,673	$9,773	$6,642	$5,439	$7,884	$36,411
FIXED ASSETS							
EQUIP - PRIOR	0	7,581	11,103	7,546	6,179	8,957	41,365
EQUIP - CURR	0	3,664	5,366	3,647	2,986	4,329	19,992
EQUIP - FULLY DEP	0	3,499	5,124	3,483	2,852	4,134	19,092
BLDG - PRIOR	0	1,232	1,805	1,227	1,005	1,456	6,725
BLDG - CURR	0	0	0	0	0	0	0
BLDG - FULLY DEP	0	0	0	0	0	0	0

NURSING HOME MANAGERS
COST ALLOCATION
SEPTEMBER 2003

	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
ALLOC PERCENT	0.00%	18.44%	26.51%	17.63%	15.56%	21.87%	100.00%
SALARIES-ADMIN	$0	$2,657	$3,820	$2,540	$2,242	$3,152	$14,410
SALARIES-CLERIC	0	1,778	2,556	1,699	1,500	2,109	9,641
SALARIES-ACTIV	0	0	0	0	0	0	0
SALARIES-NURSE	0	266	382	254	224	315	1,442
ACCOUNTING	0	(30)	(43)	(29)	(25)	(36)	(163)
WORK COMP INS	0	3	4	3	2	3	14
SUPPLIES	0	62	89	59	52	73	336
TELEPHONE	0	91	131	87	77	108	496
EMPL BENEFITS	0	795	1,143	760	671	943	4,313
PAYROLL TAXES	0	242	348	231	204	287	1,311
TRAVEL	0	63	90	60	53	74	340
IN SERVICE	0	62	89	59	52	73	334
MEDICAL CONSULT	0	0	0	0	0	0	0
MACHINE RENTAL	0	18	26	17	15	22	99
OWNERS COMP	0	156	225	149	132	185	847
INS-PROP,LIAB,WC	0	28	40	26	23	33	150
DEPRECIATION	0	137	197	131	116	163	744
RENT	0	352	506	337	297	418	1,911
MAINTENANCE	0	34	49	33	29	41	186
FEES & PUBLIC	0	0	0	0	0	0	0
ADVERTISING	0	0	0	0	0	0	0
	0	0	0	0	0	0	0
TOTAL	$0	$6,713	$9,652	$6,418	$5,664	$7,964	$36,411
FIXED ASSETS							
EQUIP - PRIOR	0	7,627	10,965	7,291	6,435	9,047	41,365
EQUIP - CURR	0	3,686	5,300	3,524	3,110	4,373	19,992
EQUIP - FULLY DEP	0	3,520	5,061	3,365	2,970	4,176	19,092
BLDG - PRIOR	0	1,240	1,783	1,185	1,046	1,471	6,725
BLDG - CURR	0	0	0	0	0	0	0
BLDG - FULLY DEP	0	0	0	0	0	0	0

NURSING HOME MANAGERS
COST ALLOCATION
OCTOBER 2003

	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
ALLOC PERCENT	0.00%	18.76%	26.41%	17.06%	15.05%	22.72%	100.00%
SALARIES-ADMIN	$0	$2,703	$3,806	$2,459	$2,169	$3,274	$14,410
SALARIES-CLERIC	0	1,808	2,546	1,645	1,451	2,190	9,641
SALARIES-ACTIV	0	0	0	0	0	0	0
SALARIES-NURSE	0	270	381	246	217	328	1,442
ACCOUNTING	0	(31)	(43)	(28)	(25)	(37)	(163)
WORK COMP INS	0	3	4	2	2	3	14
SUPPLIES	0	63	89	57	51	76	336
TELEPHONE	0	93	131	85	75	113	496
EMPL BENEFITS	0	809	1,139	736	649	980	4,313
PAYROLL TAXES	0	246	346	224	197	298	1,311
TRAVEL	0	64	90	58	51	77	340
IN SERVICE	0	63	88	57	50	76	334
MEDICAL CONSULT	0	0	0	0	0	0	0
MACHINE RENTAL	0	19	26	17	15	22	99
OWNERS COMP	0	159	224	145	127	192	847
INS-PROP,LIAB,WC	0	28	40	26	23	34	150
DEPRECIATION	0	140	197	127	112	169	744
RENT	0	358	505	326	288	434	1,911
MAINTENANCE	0	35	49	32	28	42	186
FEES & PUBLIC	0	0	0	0	0	0	0
ADVERTISING	0	0	0	0	0	0	0
	0	0	0	0	0	0	0
TOTAL	$0	$6,830	$9,618	$6,212	$5,480	$8,272	$36,411
FIXED ASSETS							
EQUIP - PRIOR	0	7,759	10,926	7,057	6,226	9,397	41,365
EQUIP - CURR	0	3,750	5,281	3,411	3,009	4,542	19,992
EQUIP - FULLY DEP	0	3,581	5,043	3,257	2,873	4,337	19,092
BLDG - PRIOR	0	1,261	1,776	1,147	1,012	1,528	6,725
BLDG - CURR	0	0	0	0	0	0	0
BLDG - FULLY DEP	0	0	0	0	0	0	0

NURSING HOME MANAGERS
COST ALLOCATION
NOVEMBER 2003

	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
ALLOC PERCENT	0.00%	18.86%	26.11%	16.84%	16.01%	22.18%	100.00%
SALARIES-ADMIN	$0	$2,717	$3,763	$2,427	$2,307	$3,197	$14,410
SALARIES-CLERIC	0	1,818	2,517	1,623	1,544	2,139	9,641
SALARIES-ACTIV	0	0	0	0	0	0	0
SALARIES-NURSE	0	272	376	243	231	320	1,442
ACCOUNTING	0	(31)	(43)	(27)	(26)	(36)	(163)
WORK COMP INS	0	3	4	2	2	3	14
SUPPLIES	0	63	88	57	54	74	336
TELEPHONE	0	93	129	83	79	110	496
EMPL BENEFITS	0	813	1,126	726	691	957	4,313
PAYROLL TAXES	0	247	342	221	210	291	1,311
TRAVEL	0	64	89	57	54	75	340
IN SERVICE	0	63	87	56	54	74	334
MEDICAL CONSULT	0	0	0	0	0	0	0
MACHINE RENTAL	0	19	26	17	16	22	99
OWNERS COMP	0	160	221	143	136	188	847
INS-PROP,LIAB,WC	0	28	39	25	24	33	150
DEPRECIATION	0	140	194	125	119	165	744
RENT	0	360	499	322	306	424	1,911
MAINTENANCE	0	35	49	31	30	41	186
FEES & PUBLIC	0	0	0	0	0	0	0
ADVERTISING	0	0	0	0	0	0	0
	0	0	0	0	0	0	0
TOTAL	$0	$6,866	$9,507	$6,132	$5,830	$8,077	$36,411
FIXED ASSETS							
EQUIP - PRIOR	0	7,800	10,800	6,966	6,623	9,176	41,365
EQUIP - CURR	0	3,770	5,220	3,367	3,201	4,435	19,992
EQUIP - FULLY DEP	0	3,600	4,985	3,215	3,057	4,235	19,092
BLDG - PRIOR	0	1,268	1,756	1,132	1,077	1,492	6,725
BLDG - CURR	0	0	0	0	0	0	0
BLDG - FULLY DEP	0	0	0	0	0	0	0